Census-Based Impact-Oriented Child Survival
in Huehuetenango, Guatemala

SECOND YEAR ANNUAL REPORT
October 1, 2003 through September 30, 2004

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By: Curamericas
224 E. Martin Street
Raleigh NC 27601
919-821-8000
919-821-8087 (fax)

Primary Authors and Editors:

Mario Valdez, MD, MPH
Curamericas-Guatemala Project Manager

Mary DeCoster, MPH
Curamericas Program Specialist

Sergio Fabricio Pérez
Curamericas-Guatemala Project Administrator

Acknowledgements

Staff involved in writing or editing this report:

Mario Valdez, MD, MPH, Curamericas-Guatemala Director

Mary DeCoster, MPH, Curamericas Program Specialist

Sergio Fabricio Pérez, Curamericas-Guatemala Project Administrator

Teresa Wolf, Curamericas Executive Director

Michael Gulley, Curamericas Director of Development

Falesha Houston, Curamericas Office Administrator

Team involved in the CS-18 annual evaluation workshop:

Mario Rodrigo Valdez, MD, MPH	Curamericas Guatemala Director
Mary DeCoster, MPH	Curamericas Program Specialist
Floricia Lisbeth Argueta	Manager of Development
Lorenza Alicia Escobar	Secretary
Sergio Fabricio Pèrez	Administrator
Edson Epifanio Gòmez	Administrative Assistant
Alma Esperanza Dominguez	Coordinator of Institutional Facilitators
Maida Audelina Calderón	Institutional Facilitator
Leandra Doreli Lòpez	Institutional Facilitator
Edmundo Morales Armas	Institutional Facilitator
Petrona Grisel Andres Pascual	Institutional Facilitator
Sara Patricia Camposeco	Education Coordinator and Akateko Educator
Maria Doricelda Domingo Sebastián	Chuj Educator
Julio Roberto Gonzalez	Information Specialist
Luciano Lorenzo Luciano	Institutional Facilitator
Maria Dolores Díaz Quiñones	Akateko Educator

I. Major accomplishments of the program

During the month of August 2004, Mary DeCoster, Curamericas Program Specialist and technical backstop for the program, traveled to the project area and participated in the program's annual planning process, with Dr. Mario Valdez, Curamericas-Guatemala Project Manager, and Sergio Fabricio Perez, Curamericas-Guatemala Project Administrator. An annual evaluation and planning meeting with project staff members was also held and their reflections on program strengths, challenges, and opportunities were very helpful in developing this report.

One of the greatest accomplishments of the program was the successful launch of the Care Groups program in the seven jurisdictions where the project is currently active. The Care Groups are run according to the model used by World Vision and others: program educators train Community Facilitators, who receive a small stipend for their work, speak the local languages and live in the communities they serve. The Community Facilitators in turn, recruit community volunteers, called Health Communicators, to share health education messages with mothers in their neighborhoods, and to collect vital events data. In some cases the Health Communicators (volunteers) visit mothers door to door, but in other communities the mothers expressed a desire to organize their own mother-to-mother support groups, or "self-care groups," which are led by the Health Communicators. Care Groups have been established in 104 out of 127 total communities targeted for services by the program.

It was very challenging initially to gain community participation. For the majority of the Akateka and Chuj women this is the first opportunity they have had to meet with their neighbors to educate themselves on health care for their children and themselves. There have been many barriers due to resistance from their husbands in having their wives participate. Even so, careful strategies were used to overcome resistance and gain trust for ensuring participation. Among the strategies was raising awareness among community leaders and opinion leaders, both male and female. This required numerous meetings and community assemblies. Another important factor in our success has been having Educators and Community Facilitators on staff that are from the local area, and are fluent in the local languages.

In organizing and gaining participation in these Care Groups and "self-care", groups it has been a challenge to maintain high levels of motivation for volunteer recruiting and retention. The health education modules and mother-reminder cards we developed have been instrumental in maintaining motivation and interest in ongoing participation. Staff educators have developed curricula or guides to accompany the modules for use during educational sessions, based on principles of participatory adult education, and have written stories, skits, and songs about health which have been translated into the local languages. This strategy has worked well to create and maintain good levels of participation.

Another notable program success has been training and participation by staff members, community facilitators, and volunteers (health communicators), and village health committees in conducting positive deviance studies in their communities and holding HEARTH home workshops to sustainably rehabilitate malnourished children. Though very labor intensive and time consuming, staff, volunteers, and community members have been very inspired and motivated by the visible and measurable improvement in children's nutritional status and health during the HEARTH sessions. Seven, two-week long HEARTH sessions have been held to date, with more planned for year three. The focus is on communities with the highest levels of child malnutrition, in the 60-80% malnutrition range, based on monthly growth monitoring activities.

We have expanded coverage in care to mothers and children less than five years of age in seven large areas of the three municipalities in our project area. This is the first time most of these people have had access to services including: immunizations, prenatal care, birth, newborn and post partum care, family planning, and care for children with diarrhea, acute respiratory infections, and malnutrition. Before this project began the mothers had to travel as many as 25 to 30 kilometers for access to health care services, often on foot, making it practically impossible for them to seek out care.

The project staff has worked hard to achieve good coordination and collaboration with the Ministry of Health and area health institutions. This has helped the project obtain the acceptance needed in the communities, has optimized the use of resources and has improved coverage in the health interventions that have been initiated in each of the communities. Good coordination with the municipal authorities has increased community leaders' awareness of health problems and has encouraged more municipal involvement in taking responsibility for improving the quality of life for the children and women in the area. We plan to include the Ministry of Health and the municipal governments in the midterm evaluation process in year three of the project. This will help build their awareness and support for future sustainability of health improvements that are being made during this child survival project.

Plans for project phase out are already being actively discussed in the project area at all levels of the community. During volunteer recognition events, speeches included discussion of ways that Care Group activities might continue and how volunteers might continue to provide information and support to new mothers "when the project ends." Positive Deviance / Hearth interventions are intended to change knowledge and practices rapidly, and are not meant to be continued indefinitely. The new knowledge gained and the new behaviors will persist in the communities served, helping prevent the suffering of malnutrition in children yet to be born. Talks are ongoing with the Ministry of Health and municipalities for ways to continue to provide services in the remote rural outposts. Community Health Committees are aware of the need to advocate for municipal funding for health services in their communities. The project personnel are doing a good job of preparing the community and using multiple strategies to plan for project phase out and sustainability. Curamericas Guatemala is also looking for other funding sources and opportunities to serve families in nearby communities that are not yet receiving health care and preventive health education.

Field Activities completed:

- Census and community mapping in Phase II communities.
- Selection and training of Community Facilitators
- Community Facilitators began health activities and health education activities
- Recruited volunteers (Health Communicators) for Phase I and Phase II communities and began teaching activities with modules and mother-reminder cards.
- First Annual Mini-KPC survey completed in December 2003
- Began monthly training sessions for traditional birth attendants
- Monthly Growth Monitoring and Health Promotion outreach posts are being held concurrently with Immunization, Deworming and Micronutrient outreach events.
    - Introduction to Nutrition and Malnutrition Workshop
    - Positive Deviance Workshop and Positive Deviance Investigation Practicum
    - HEARTH training
    - Training of Trainers held for auxiliary nurses and doctors on emergencies in maternal/newborn care by JHPIEGO trainers
    - Traditional Birth Attendants, Health Promoters, and Community Facilitators were trained on emergencies in childbirth and birth plans by JHPIEGO trainers

- Project educators were trained on community organizing for the development of community emergency plans by JHPIEGO trainers
- Review session on Supervision and Quality Assurance
- Review session on methods of Non-Formal Adult Education Training
- Review session Nutrition, Malnutrition, and Micronutrients
- Child Spacing Training

- Health care services are being provided in seven jurisdictions, three with personnel funded by the project, and three funded by the Ministry of Health. Services include:
  - Consults for children under five
  - Growth monitoring for children under five
  - Sick visits for women of reproductive age
  - Immunizations, micronutrients, deworming
  - Prenatal, childbirth, and postpartum care and family planning services

TABLE 1: PROGRESS TOWARDS TECHNICAL OBJECTIVES

Objectives: Technical	Progress on Target?	Comments
Decrease the percentage of children age 0-23 months who are underweight from 43% to 34%	Yes	The project is having encouraging results success through growth monitoring and promotion (GM/P), use of micronutrients and deworming, Positive Deviance / Hearth (PD/Hearth), and Care Group educational activities.
Increase the percentage of children 0-5 months who were exclusively breastfed during the past 24 hours	Yes	Results from a barrier analysis study on exclusive breastfeeding versus bottle usage have been very useful in promoting exclusive breastfeeding in the project area.
Increase the percentage of mothers of children 0-23m who received a Vitamin A dose during the first two months after delivery from 0% to 60%	Yes	Although the Ministry of Health of Guatemala does not support this protocol, the district directors are supporting this practice. We also obtained supplies of Vitamin A from MAP international, which were imported with assistance from the USAID mission in Guatemala.
Increase the percentage of mothers who had at least two prenatal visits with a trained health provider prior to the birth of her youngest child less than 24 months from 25% to 40%	Yes	
Increase the percentage of children age 0-23m whose births are attended by skilled health personnel (nurse, auxiliary nurse, or MD) from 9% to 18%	Yes	Pregnant women are being entered into the health information system (through Care Group volunteers' vital events reporting), facilitating follow up through the prenatal, birth, and postpartum period.
Assure adequate child spacing for all mothers. Increase the percentage of mothers who know at least one place where she can obtain a method of child spacing from 41% to 65%	Yes	The Ministry of Health is providing supplies and there has been good promotion through Care Groups.
Increase the percentage of children 0-23m with diarrhea who were given the same amount or more liquids during the illness from 29% to 50%	Yes	Promoted through health facilities, Care Groups, and PD/Hearth.
Increase the percentage of children age 0-23m with diarrhea who receive ORS and/or recommended home fluids from 18% to 42%	Yes	Promoted through health facilities, Care Groups, and PD/Hearth.
0% of health facilities will not have had a stock-out of essential medications / supplies in the previous month	Yes	There is improvement in this area, most essential supplies and medications are available. Still lacking at times are prenatal vitamins and iron for pregnant women.
80% of health workers score greater than 80% on IMCI (AIEPI) checklist in the past quarter	No	IMCI training has been postponed until February 2005 because of the program was undergoing revision at the national level, and because of the lack of a functioning reference chain in the project area.

90% or more of the health facility workers and CFs will correctly assess danger signs in sick children	No	See above, the IMCI training has been postponed, so this is not currently being assessed.
100% of the health facility workers and CFs will have received a supervision visit at least once in the last three months using verification checklists	Yes	Staff has been trained, and reviewed in use of verification checklists for quality assurance. There is now a district director in San Rafael available to help with supervision, and a staff nurse has been reassigned to a primarily supervision and support role for project staff
Increase the percentage of children age 13-23 months who were fully vaccinated from 42% to 75%	Yes	Completed census lists in Phase I and Phase II Communities have greatly assisted with this process.
Increase the percentage of mothers of children 0-23 months who receive at least two tetanus toxoid injections before the birth of the youngest child from 16% to 28%	Yes	The project has already achieved this goal in some jurisdictions.

TABLE 2: PROGRESS TOWARDS CAPACITY BUILDING OBJECTIVES

Objectives: Capacity Building	Progress on Target?	Comments
Increase private charitable donations at headquarters from $137,225 to $164,670 over five years	Yes	In year two, Curamericas hired a new executive director and a director of development, both with extensive experience in successful fundraising.
Expand Curamericas child survival activities to program operations to two new countries	Yes	Curamericas plans to take the lead on one CS-21 proposal and to collaborate with other PVOs on a second proposal.
Assure standardization of the CBIO methodology across countries; standardize educational materials for field offices.	Yes	Work is in process to produce a CORE funded CBIO manual and standardized educational materials. Completion expected Dec. 15, 2004

TABLE 3: PROGRESS TOWARDS SUSTAINABILITY OBJECTIVES

Objectives: Sustainability	Progress on Target?	Comments
Child health activities are eventually sustainable locally. Increase the % of the beneficiaries who live within 5 kilometers of a health post with at least one health worker trained in AIEPI / IMCI protocols	Yes/No	Many communities that previously had no access to services now are within 5 kilometers of a health post. There will be more IMCI trained health workers in year three.
Curamericas-Guatemala will promote child survival activities to the municipal governments by attending at least 10 meetings annually of the Municipal Development Committee in the three municipalities	Yes	This has been done in the two municipalities in year two, and the third municipality will be added in year three.
Establish sustainable Care Groups in all project communities	Yes	There is good progress towards this goal, but it is a slow process to build trust and build participation in new project communities.
Increase local monitoring and evaluation capacity – Ninety percent of Institutional Facilitators will be able to do a Rotating Mini KPC survey properly, based on check-list scores	Yes	The second annual Rotating Mini KPC survey will take place in December; staff will be evaluated using verification checklists.

II. What factors have impeded progress towards achievement of overall goals and objectives and what actions are being taken by the program to overcome these constraints?

One difficulty has been in the recruitment of Community Facilitators. The high percentage of illiteracy (83%) among women in the project area has been a factor, since literacy is very helpful in record keeping and health promotion activities. Machismo has also been an issue, as in many communities women are not allowed to leave the home without their husband's permission, or in some cases, without their husband accompanying them. Low self esteem and high workloads among the women have also made it difficult to gain desired levels of participation in project activities. We have had to resort to recruiting male Community Facilitators in some cases, which is actually working out reasonably well. Community wide meetings to explain the aims of the project have also helped reduce male concerns about women's participation. Husbands and other family members are welcomed at Care Group meetings as well and this helps to reduce suspicion and concerns about what the women are learning.

Staff requires a lot of support and training; many of them began the project with little to no knowledge of preventive health behaviors, nutrition, and principles of adult education. Multiple training sessions to review and reinforce previous workshops have been added and are included during each of Mary DeCoster's backstopping visits. Additional trainers are also brought in to provide workshops. Molly Holhauser, a graduate student in public health, will be spending 7 months volunteering with project staff in year three to support the team in all areas of the nutrition intervention, and, with extensive support and supervision from the project backstop, will put into place systems for monitoring and evaluation of the PD/Hearth process.

Another challenge has been to reach agreements with an NGO that had agreed to collaborate during project planning, but now when it is time to implement phase III of the project and begin working together, ASDIC (Asociación para la Salud y el Desarrollo Integral Coataneco -- Coatan Integrated Health and Development Association) has declined to sign formal agreements with regards to coordinating our work in the San Sebastian Coatan municipality. ASDIC staff members have indicated an interest in collaborating and coordinating work, but the ASDIC board is still holding talks with Curamericas Guatemala. ASDIC is funded through the Ministry of Health to provide some health services, but has no education and outreach activities. Program staff members plan to be in communication and to coordinate activities with ASDIC whether or not a formal agreement is reached, but a signed agreement would be preferable.

A number of factors have led to the decision to delay having staff members trained in Clinical and Community IMCI. The IMCI program is undergoing revision at the national level, and the revised version is due to be released early in 2005. Three staff members have been trained in IMCI (two in clinical and one in community IMCI) in year one of the project. They expressed serious concerns about the feasibility of implementing IMCI because the reference chain in the project area is extremely dysfunctional. A corner stone of IMCI involves identifying a child (or newborn) at risk, and immediate referral to a hospital or health center. Impassible roads, lack of transportation, lack of referral centers, and the abysmal quality of services at the local hospital in Huehuetenango (4-6 hours travel from the project area) caused staff to feel very uneasy about trying to implement IMCI, and they strongly recommended waiting. This year the referral situation has improved: there is a trustworthy maternity center -- Project Concern International (PCI) has a new maternity center in Huehuetenango, and the roads and public transportation system are better. In addition, the Ministry of Health has finally hired a district director for

San Rafael la Independencia (a medical doctor trained in IMCI) and is in the process of hiring another district director for San Miguel Acatan. So, now there are some referral options for community members in case of emergencies. In year three of the project it will be possible for all staff to receive the revised IMCI training and to implement IMCI in all the health posts at once. Community Facilitators and health educators will receive Community IMCI training, will reinforce knowledge of IMCI danger signs through the Care Groups and will refer emergency cases to the district health centers and to PCI's maternity center in Huehuetenango.

Cultural differences in the level of community participation in different project areas continue to be challenging. The areas where the Chuj language is spoken tend to be more open to project interventions, delivery of services, and participation in educational activities. The Akateko speaking areas, around the San Miguel Acatan municipality are where community participation rates are lowest. The project team continues to look for strategies to increase participation and acceptance among these communities. Machismo is more pronounced among Akateko communities, and at community meetings the men have insisted on their right to forbid women to go to meetings, or indeed to even go out in public without being accompanied by their husbands. There are also numerous myths among the Akateko about the dangers of immunization, but some progress is being made. At a recent community meeting held to organize Care Groups, there was a great deal of discussion about beliefs and misinformation about immunization. The Institutional Facilitator, with help from Community Facilitators and volunteers, was able to convince the Assistant Mayor to support vaccination of women and children in the community.

Logistical issues continue to be very challenging as well. The team of Curamericas Guatemala is very dedicated and committed to their work, but the barriers of distances, bad roads, and community resistances make things progress slower than planned, at times. In spite of these challenges many program objectives are being achieved, and project staff feel inspired and encouraged that the program is producing sustainable results in reducing the suffering from malnutrition and disease, and helping the women and children to become healthier.

III. In what areas of the project is technical assistance required?

Technical assistance will be needed in preparing for the mid-term evaluation. Guidance will be sought from the CORE group in selecting an evaluator who can help make this a positive learning experience for all. Additional guidance will be sought from CSTS staff and the USAID project backstop on timelines and appropriate steps for planning and carrying out the mid-term evaluation.

IV. Describe any substantial changes from the program description and DIP that will require a modification to the cooperative agreement. Discuss the reasons for these changes.

There are no substantial changes in the program.

V. For projects in their first or second year: If specific information was requested for response during the DIP consultation for this program, please provide the information as requested.

Not applicable -- no specific information was requested for response during the DIP consultation for this program

VI. For projects receiving Flexible Fund support:

Not applicable

VII. Describe the programs management system and discuss any factors that have positively or negatively impacted the overall management of the program since its inception.

- ***Financial management system****:*
  - The results from the first financial audit were very helpful and several important procedural changes have been implemented based on recommendations from the audit. Preparations are underway for the second audit.
  - The computerized accounting software system is now in use and is backed up by a manual system.
  - Every three months, headquarters staff receives the field staff's Standard 269 report outlining the expenses incurred in the execution of the project. These reports have been timely and accurate.
  - Gladys Shanklin, Curamericas program administrator, has visited the staff in Guatemala and provided a substantial support in developing good reporting systems. She continues to support administrative staff through phone calls, faxes and email.

- *Human Resources*
  - The program has been very fortunate in the high caliber of staff recruited. There have been very few problems with human resources in the second year of the program. There has been some staff turnover due to personal reasons (health, relocating with spouse). The biggest challenge has been finding personnel who are willing to work in difficult conditions, in rural areas, and far from their families, and who speak the local languages (Chuj and Akateko). The staff members who have been recruited have demonstrated a real commitment to the program, its communities, and to their learning process.
  - The biggest changes in the program have been the promotion of one Institutional Facilitator to Supervisor, due to recognition of her abilities and the need to support each one of the jurisdictions. She will be active in supervision and monitoring, with the support of the director. One of the educators was also promoted to Lead Educator, to provide more support and supervision for the educators and community facilitators. There are currently 16 paid staff members with Curamericas-Guatemala:
    - ✓ One program director
    - ✓ One administrator/accountant
    - ✓ Manager of development (part-time)
    - ✓ Secretary (part-time)
    - ✓ Administrative Assistant
    - ✓ One Information Technology/Health Information Systems Specialist
    - ✓ Seven Institutional Facilitators/ Auxiliary Nurses
    - ✓ Three health educators
  - Each worker receives benefits such as vacation days, indemnification, life and medical insurances, and bonuses according to the standards of Guatemalan law.
  - Workers present reports describing their activities for the previous month and their projected work plan during the technical meetings held at the end of each month.
  - Community Facilitators are paid a small stipend and do not work full time. They do not receive benefits. There are currently 20 Community Facilitators.

- *Communication System and Team Development*
    - Communication continues to be challenging. Telephone and fax lines have finally been installed in the office in San Miguel. Due to frequent power outages, the telephone lines are not reliable. Staff still must travel to larger towns to check internet, usually to Huehuetenango. Satellite telephones only function in some parts of the project area, due to lack of satellite towers and interference from the mountains. The project team has learned to adapt to this situation, and to make plans well in advance, because last-minute communications are often difficult or impossible.
    - Team Development: Staff had been meeting once a month to plan and coordinate their activities and to provide each other with information and support, but found that they needed to meet twice a month. The project staff also makes a point of taking time for team building activities. Staff members contribute to a fund for staff trips in the spring and fall – many staff members have never seen some of Guatemala's major attractions, and these trips a very positive team building experience for all. So far they have visited the ocean and Lake Atitlan. In March, they have planned a trip to a volcano. Strong, supportive leadership and good conflict resolution skills have also contributed to keeping staff cohesion and morale strong.

- *Local Partner Relationships*
  Curamericas' new executive director, Teresa Wolf, visited the project area and met staff members as well as many community facilitators and volunteers. Her open and collaborative approach has strengthened relationships between the local partner and headquarters. The local partner, Curamericas Guatemala, sees the change in leadership as very positive. Project staff members, as well as the project director, Dr. Mario Valdez, have stated that they are pleased with the level of technical and administrative support they receive from headquarters, which is very helpful in the implementation of the program.

- *PVO coordination/collaboration in country*
  Curamericas Guatemala has achieved good coordination and collaboration with the Ministry of Health at the departmental and district levels. There has also been good collaboration with other NGOs in training. The maternal newborn care workshops were provided by JHPIEGO, the Family Planning workshop was provided by APROFAM, and we have received help from Calidad en Salud with educational material. All three of these NGOs receive support from USAID. Project Concern International has visited our project to learn more about our Positive Deviance / Hearth program for addressing child malnutrition.

- *Other relevant management systems*
  Not applicable.

- *If an organizational capacity assessment of any kind has been conducted during the LOP describe how the PVO program has responded to the findings*
  Gladys Shanklin completed the already in process organizational capacity assessment during her visit to the project area, and worked with Sergio Perez, project administrator, to implement the recommended changes. The recommendations from the audit were also actively implemented.

AUDIT RECOMMENDATIONS	ACHIEVEMENTS
Implementation of an inventory system	Supplies and Vehicles have been coded to identify their location
Implementation of special receipts	When receipts are not available, special receipts are now printed and provided to merchants who do not use receipts, to avoid tax evasion
Improved accounting system	Implementation of a computerized and manual accounting system
Identification of buildings and vehicles	Buildings and vehicles have been painted to display the association's name and USAID program support
Reduce losses due to monetary devaluation	A banking account in dollars has been established and procedures are in place to minimize losses due to constant devaluation of the quetzal (Guatemalan currency).

VIII. Detailed work plan for the coming year

Curamericas Guatemala CS 18
Project Activities Timeline

Project Year #3 (FY 2005)		
Activity	**Time Period**	**Staff Responsible**
Selection of remaining Community Facilitators and orientation / initial training	November and December 2004	Education Coordinator (EC), Institutional Facilitators (IFs)
Census and CBIO training for new Phase III staff	November 2004	Education Coordinator (EC), Institutional Facilitators (IFs) and Project Director
Community Mapping and pre-census activities for Phase III census areas	November 2004	Education Coordinator (EC), Institutional Facilitators (IFs) and Assistant Mayors
Census of all Phase 3 communities	November 2004 thru February 2005	Institutional Facilitators (IFs), Community Facilitators (CFs) and Health Communicators (volunteers)
Form Care Groups in Phase 3 communities, volunteer selection, initial training	From December 2004 through February 2005	Education Coordinator, IFs, CFs
Second year audit	November 2004	External Auditor, support from program administrator
Annual Mini KPC survey	December 2004	Information Specialist, IFs, CFs
New Community Facilitators begin community health activities	January 2005	Education Coordinator, IFs
Care Group Meetings begin in Phase III communities	January 2005	Community Facilitators
Technical Advisory Committee meetings begin in phase III municipality	February 2005	District Director(s) and Project Director
Nutrition review course (in-service training)	February 2005	Program Specialist
Positive Deviance/Hearth training for Phase III personnel	February 2005	Program Specialist
Growth Monitoring and Promotion Review course	February 2005	Program Specialist
Immunization Training, Phase III staff	March 2005	Ministry of Health, Project Director
Training in Clinical IMCI for clinical staff	March 2005	Ministry of Health, Project Director
Training in Community IMCI for clinical and community staff IFs, FCs, Educators, Volunteers	April 2005	Ministry of Health, Project Director

Activity	Time Period	Staff Responsible
Pocket PC training	April 2005	Information Specialist
Community Facilitators train Health Communicators (volunteers), volunteers share information with mothers, on participatory education modules #4 thru #7	Beginning April 2005	Community Facilitators, Communicators (Volunteers)
General Inventory, and Inventory by Jurisdiction	April 2005	Administrator
Maternal Newborn Care workshop, phase III personnel	May 2005	Education Coordinator, Institutional Facilitators' Coordinator, Project Director
Institutional Facilitators progressively train Community Facilitators in the new areas (phase III) on all interventions and all educational modules.	Beginning June 2005	Institutional Facilitators
Prepare for Midterm Evaluation	February 2005	Form Evaluation Team, begin planning and preparations for evaluation
Midterm Evaluation	June 2005	External Evaluator approved by USAID and Evaluation Team
Training in management of Pneumonia and Acute Respiratory Infection	July 2005	Ministry of Health, District Health Director
Barrier Analysis Training, Phase Three Personnel	August 2005	Program Specialist
Response to Midterm Evaluation, revise implementation plan, annual planning process at Curamericas HQ	September 2005	Program Specialist(s), Program Administrator, Project Director, Executive Director

IX. If the program has some key issues, results or successes, or if the program has identified a new methodology or process that has serious potential for scale up, please provide a one-page highlight if appropriate.

Not applicable

X. If a topic in these guidelines does not apply to the program; please indicate this in the Annual Report.

This has been done where a topic does not apply.

XI. Include in the Annual Report, other relevant aspects of the program that may not be covered in these guidelines.

Not applicable